

## **ISDH Zika Virus Testing Authorization Form**

Please complete all fields of this form. All fields **MUST** be completed in order for testing to be authorized. Incomplete forms will result in a delay in authorization. Requests will be approved via <a href="mailto:emailto

Provider Infor	rmation				
Provider Nam	e:				
Facility Name	and Address:				
Facility Phone	Number:		<del>-</del>		
Point of Conta	act Name:				
Point of Conta	act <b>email addres</b>	s:			
Patient Inforn	nation				
Name (first an	nd last):				
Indiana count	y of residence: _				
Date of birth:			Sex: M F		
Pregnant?	Υ	N	If yes, estimated date of	delivery:/_	/
Symptoms?	Υ	N	If yes, date of symptom	onset:/	/
If yes,	please indicate:	:			
	Fever	Rash	Arthralgia Conjunc	tivitis	
	Other:				
Suspect sexual transmission?				Υ	N
Has the patient traveled to an area with Zika*?					N
Has the patient's sex partner traveled to an area with Zika*?					N
If yes,	location of trav	el:			
Exact	dates of travel:		to//		
(*As defined b	oy CDC's "Areas	with Zika" w	ebpage: <a href="http://www.cdc.gov/z">http://www.cdc.gov/z</a>	ika/geo/index.hti	<u>ml</u> )

Upon completion of this form, **please fax to the ISDH at 317-234-2812**. An ISDH epidemiologist will follow-up with Zika virus testing authorization requests within 1 business day. For additional questions, please contact the ISDH Epidemiology Resource Center at 317-233-7125.